THE OPERATION OF THE CLINICAL TEAM IN THE INTENSIVE TREATMENT UNIT AT NORTHVILLE STATE HOSPITAL

A THESIS

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CHAPTER I

INTRODUCTION

Significance of the Study

Mental illness has existed since the beginning of mankind. It makes no distinction of social levels, groups, nationalities, religions, or occupations; it attacks indiscriminately and is so widespread that nearly everybody knows someone who is a patient in a mental hospital. Treatment of the mental patient has gone through numerous stages. The early means of treatment were repressive, isolatory, and purely custodial. Increased knowledge of mental illness, however, caused attention to be given to the possibility of a more scientific understanding of it. Psychiatry searched for the best possible methods of treatment and by the turn of the twentieth century achieved significant insight into the problem of mental illness. This was revealed by the contributions of Dr. Adolph Meyer, Sigmund Freud, and others who developed dynamic approaches to psychiatric theory and practice in the period from 1905 to 1915 when there was a shift of interest from diagnosis and classification of mental diseases to the consideration of the personality of the patient in relation to his environmental situation. Since this shift the mental patient has been viewed in the following perspective:

> In modern psychiatry the patient no longer appears as a fragment of psychopathology but as a human being in a structural social situation, a part of an organic social group, who is involved in a complicated system of

> interpersonal relationships, and whose inner tensions and conflicts are inseparably bound to his social matrix.[1]

Changes have occurred also in the treatment of the mental patient. This is partially seen in the development of the clinical team. The clinical team, which is a multi-disciplinary approach to the treatment of mental illness, was given impetus out of the concept of sharing and pooling the skills of medical and non-medical staff in order to provide the most effective treatment for the mentally ill patient. Although the clinical team usually consists of the psychiatrist, psychologist, social worker, and the psychiatric nurse, it has been difficult to outline the first un-organized beginning of the focusing or drawing together of these mental health professions.

The utilization of the services of non-medical persons in the treatment of the mentally ill in the United States was introduced in the following sequence: the psychiatric social worker being first, the psychologist being second, and the psychiatric nurse being third. Hundreds of hospitals in the United States, in making the transition from custodial care alone to the latest and most complete psychiatric treatment, realized that each of these professions played a dynamic role in effecting the transition. The advent of each of these professional members to the clinical team shall be discussed in

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[1]Group for the Advancement of Psychiatry, Psychiatric Social Work in the Psychiatric Clinic, No. 16 (Topeka, 1950), p. 1.

the chapter on "The Development of the Clinical Team in State Mental Hospitals of America."

The writer's reasons for making this study were both practical and theoretical. The practical interest arose out of the writer's awareness that medical and psychiatric agencies, and other agencies have found it effective to use staff teams composed of persons from various disciplines in order to serve their clientele more adequately. The writer's theoretical interest arose out of the awareness that each team member belonged to a different profession and brought different points of view to the co-operative endeavor. Interest in the study was enhanced also by the understanding that the administration at Northville State Hospital desired information on the effectiveness of the team approach to the treatment of mental patients in that hospital. The writer anticipated that the study would have meaning for the field of social work.

Purposes of the Study

The purposes of this study were: (1) to point out the historical development of the use of the clinical team in the treatment of patients in state mental hospitals in America, and (2) to describe the operation of the clinical team in the treatment of patients in the Intensive Treatment Unit at Northville State Hospital.

Method of Procedure

The writer used three spheres of reference in securing data for this study. Books, pamphlets, and reports regarding

the concept of the clinical team were read. Schedules were constructed for interviews with team members at Northville State Hospital regarding their concepts of role functioning in the treatment process out of the framework of the theoretical information obtained from the literature that was read. From the daily census for the period of January, 1957 to January, 1958 it was found that 100 patients were placed on convalescent status from the Intensive Treatment Unit. By the use of the random sampling method, a 10% sample was drawn from this group, and ten cases were read.

Scope and Limitations

This study was confined to a descriptive presentation of the operation of the clinical team in the Intensive Treatment Unit at Northville State Hospital. It was limited to the reading of ten case records of patients placed on convalescent status during the time span of January, 1957 to January, 1958. Another limitation of the study was the fact that there was not complete coverage of clinical teams on each of the wards in the unit; therefore interviews were held with only seven psychiatrists, four psychologists, four nurses, and eight social workers. The study was limited further as the writer and four other social workers assigned to the unit had limited experience in the practice of social work in a psychiatric setting.

CHAPTER II

THE SETTING OF THE STUDY

Northwest State Hospital, located twenty-seven miles northwest of downtown Detroit, Michigan, was one of six psychiatric hospitals operated by the Michigan Department of Mental Health for the care and treatment of the mentally ill and those addicted to narcotics or alcohol. The hospital had an extensive training and research program.

> It has a three year psychiatric residency training program through affliation with the American Psychiatric Association; it provides internships to Master's Degree candidates from the schools of social work at the University of Atlanta, Georgia, University of Michigan, and Wayne State University. A practicum in clinical psychology for graduate students from Wayne State University is provided; affliations in occupational therapy for students from Eastern and Western Michigan Colleges, Wayne State University, and other approved schools for occupational therapy are also provided. Advanced psychiatric nursing students from Wayne State University College of Nursing may also receive two semesters placement at the hospital. The hospital also provides three month affliations to basic nursing students from Michigan State University, Harper Hospital, Mercy Central of Grand Rapids, and Henry Ford Hospital. [1]

The hospital received its first group of patients on January 15, 1952.[2] Since that time the census has increased from twenty-five to a total hospital population of 2,078

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[1]Northville State Hospital, "A Short Story of Northville State Hospital" (Northville, Michigan, 1957), p. 2 (Mimeographed).

[2]Northville State Hospital, "Teamwork Is the Key for Treatment of Mental Illness" (Northville, Michigan, 1957), p. 1. (Mimeographed).

according to the daily census for February 27, 1958. Patients admitted to the hospital were usually residents of Wayne County, Michigan. The procedures utilized for the admission of patients to the hospital were: (1) by regular commitment, and (2) by voluntary commitment. In the former type of procedure, the patients were committed by the Judge of Probate Court on the basis of a petition having been filed in Probate Court stating that the patients were mentally ill and needed hospitalization; these patients had to remain in the hospital until the medical staff felt that it was advisable for them to leave or their rights were restored by the court. In the latter procedure, the patients, recognizing that they had a psychiatric problem, requested permission from the medical superintendent or the assistant superintendent to be admitted to the hospital; the decision for their admission, however, had to be sanctioned by the Judge of Probate Court. Patients admitted to the hospital on a voluntary commitment were able to request release from the hospital at any time, and this request had to be granted within five days from the time that it was made.

Northville was new and still in the process of construction, both as to buildings and as to staff. It was under the direction of a medical superintendent, Phillip Brown, M.D., who was a psychiatrist. The heads of the various clinical departments were on the administrative staff and all worked cooperatively in building the hospital program and in formulating the hospital policy. There were approximately 900 employees

at Northville, about 570 of whom were assigned to the medical section. The staff was supplemented by a large number of volunteer workers from civic and fraternal organizations.

The hospital was divided into six units, and they were: the Admission Unit, the Medical Unit, the Geriatric Unit, the Chronic Unit, the Intensive Treatment Unit, and the Children's Unit. In this study the writer was concerned with the Intensive Treatment Unit.

In the Intensive Treatment Unit there was a bed capacity for 290 patients on ten separate wards. The unit had office space for individual psychotherapy; the living-rooms of the unit had ample space for ward and staff personnel to conduct ward meetings with the patients. The unit had its own occupational therapy suites, snack bar, beauty shop, and gymnasium, as well as offices and classrooms for teaching and training purposes. Patients were admitted to the unit after a diagnosis and plan of treatment were made; this was done usually within six weeks after the patients were admitted to the hospital. Not all patients responded to treatment at the same rate of speed. Some patients were able to return to their homes within a relatively short time; others needed treatment for a longer period of time. In the latter cases the patients were transferred from the unit to a Chronic Unit where programs appropriate to their needs were available.

Treatment of patients included atropine, electro-convulsive therapy, PM-10-90, psychotherapy, and group therapy.

Concurrently the patients had regular schedules of activities which included contact with the special services, such as psychology, social service, occupational therapy, and work therapy. The treatment program of the hospital was geared to a multi-disciplinary approach to the treatment of mental illness. The psychiatrist was the team leader and conferred with all of the members of other departments who were assigned to work with him. Ward meetings, therapeutic conferences, diagnostic staffs, and other teaching programs were held in addition to daily ward rounds and weekly consultations with the team social worker. The members of the professional discipes composing the clinical teams on the wards of the Intensive Treatment Unit were the psychiatrist, psychologist, social worker, and the psychiatric nurse. Each of these persons made contributions to the treatment of the mentally ill patient. This study was centered on the operation of this team in this specific unit at Northville State Hospital.

Prior to the description of the operation of the clinical team at Northville State Hospital, it seemed important to discuss the historical development of the clinical team in state mental hospitals in America. The following chapter is composed of this discussion.

CHAPTER III

THE DEVELOPMENT OF THE CLINICAL TEAM IN STATE MENTAL HOSPITALS OF AMERICA

As the nineteenth century terminated and the twentieth century commenced, psychiatry achieved significant insight into the problem of mental illness. There were a host of contributors to this achievement, but none were more important than Sigmund Freud and Dr. Adolph Meyer.

> Freud formulated the dynamics of personality structure and functioning, and he developed a psychotherapeutic method for the treatment of emotional conflicts. His theories deepened the understanding of human motivations and the causes and nature of personality disorders.[1]

Dr. Meyer's theory of psychobiology also helped to usher in the period of scientific understanding of mental illness.

> Psychobiology emphasizes the importance of the patient as a person and yet as a natural, biological creature whose total life history as well as his physical and mental capacities must be studied in order to understand his behavior and his problems. The etiologic bases of the mental disorder are multiple as the individual is regarded as a human organism, as a natural biological phenomenon, a physical-chemical-social-psychological interacting unit. Mental illness is regarded as a psychobiological response to the special complex life situation in which the individual is placed.[2]

The psychiatrists during this period of awakening were called upon to understand more than the anatomy of the brain in order to diagnose and treat a mental disorder successfully;

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[1]Herbert H. Stroup, Social Work: An Introduction to the Field (New York, 1948), p. 400.

[2]Arthur P. Noyes, Modern Clinical Psychiatry (Philadelphia, 1953), p. 88.

they had to know all that went into the organization of the personality of the patient, from within and without. In order to achieve this goal, the skills of non-medical staff personnel had to be utilized. Out of the realm of thought of psychiatrists during this period, the concept of the use of the clinical team in the treatment of mental illness was initiated. This concept, which is a multi-disciplinary approach to the treatment of mental illness, should be considered against a background of approximately fifty-three years. Commenting on the concept of the team approach to mental illness, Lois French wrote:

> According to a state hospital superintendent in an eastern state, the problems of a mental patient should be approached by a team which should consist of the psychiatrist, psychologist, psychiatric social worker, and the psychiatric nurse. Each of these individuals has his own particular status with the patient, and it is only by the pooling of the information obtained by observation and interview that any adequate program for the patient can be worked out.[1]

The clinical team is a unit, usually headed by the psychiatrist, which brings into focus the unique and overlapping knowledge, skills, and techniques of each discipline for the treatment of the individual patient. In a close multi-professional team, each member pools his unique services toward a common purpose designed to meet the fundamental needs of the patient.

Difficulty arose when attempts were made to trace the

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[1]Lois Meredith French, Psychiatric Social Work (New York, 1940), p. 132.

first un-organized beginning of the focusing or drawing together of the disciplines of psychiatry, social work, psychology and nursing in the mental hospitals. The social worker, however, was the first non-medical member to be added to the clinical team in the mental hospital. The first evidence of this factor was the employment of a social worker in the Neurological Clinic of the Massachusetts General Hospital in Boston in 1905; the services of the social worker were utilized by the clinic as an aid for a more accurate diagnosis and a more effective treatment of mental illness. In 1906, a social worker was employed at the Bellevue Hospital in New York. The social worker's advent into the state mental hospital, however, did not exist until 1911 when the Manhattan State Hospital, through the influence of the New York Committee on Mental Hygiene, hired a social worker to ease the adjustment problems of the discharged patient as he sought to re-establish normal personal and community relationships. In Massachusetts, similar interest in after-care led, in 1913, to the appointment of social workers at Danvers and Boston State Hospitals.

> In the same year the Boston Psychopathic Hospital organized its social service department to assist in the study and treatment of mental disease in that hospital.[1]

Treatment was construed in its broadest sense to mean the

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[1]"Psychiatric Social Work," Social Work Yearbook, 1957.

restoration of the capacity for normal living or provision for the greatest comfort.[1] The use of the term, psychiatric social work, to designate social work with mental patients, also originated in the social service department of the Boston Psychopathic Hospital, under the auspices of Miss Mary C. Jarrett in 1913.

> By 1918 psychiatric social work was established in state hospitals of many states as the effects of World War I stimulated the development of training facilities and defined the scope and function of the psychiatric social worker.[2]

As an aftermath of World War II, with its increased emphasis upon the importance of psychiatric treatment and the passage of the National Mental Health Act by Congress in 1946, attention was focused upon a further clarification of the structure and objective of the clinical team. The second nonmedical member to be added to the clinical team in the mental hospital was the clinical psychologist. Although the psychologist's clinical function was initiated in the University of Pennsylvania Psychological Clinic in 1896, his role consisted primarily of administering tests designed to determine the presence or absence of mental deficiency. Paralleling the development of this clinic was the establishment of psychological laboratories in St. Elizabeth's Hospital, Boston Psychopathic Hospital, and the Worcester State Hospital. In these

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[1]Lois Meredith French, op. cit., p. 38.

[2]Herbert H. Stroup, op. cit., p. 408.

centers there was, for the first time, a limited association of the psychologist with the psychiatrist and the social worker. The importance of the services of the clinical psychologist to the treatment of patients in mental hospitals was not recognized until it was realized that his training in the broad principles of behavior and learning and the relation of these to the origin and development of behavior disorders made it possible for him to contribute essential information to the total psychodynamic picture by the administering of projective tests. The projective tests of personality are a valuable tool for the understanding of the dynamics of the patient's maladjustment.

> In the task presented by the integration of data from various disciplines concerned with the study of a patient-- particularly in bridging the gap between extremes provided by psychiatric and physiological-biochemical data-- the psychological material is in a favorable position. Its position is strategic because, on the one hand, its more controlled and objective nature makes it adaptable for correlation with physiological and biochemical material and, on the other hand, its behavioral and higher-level functional nature makes it directly comparable with the psychiatric and social data.[1]
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> In addition to the final goal of integrating the psychological findings with those of the other disciplines, the psychological program has another aim, that of establishing a unified psychological portrait of the individual patient. This picture is derived from a battery of tests.[2]

Because of his training in the design of experiments in the application of research methods to clinical problems encountered by the service-oriented therapeutic

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[1]Franz Alexander, M.D., and Helen Ross, Dynamic Psychiatry (Chicago, 1952), p. 468.

[2]Ibid.

> team, the psychologist can contribute a valuable corrective to the tendency to rely unduly on subjective judgment in clinical work.[1]

The last member added to the clinical team was the psychiatric nurse. Although there were too few trained personnel in every discipline associated with the mental health field, the shortage of nursing personnel was the greatest. In making the transition from custodial care alone to the latest and most comprehensive psychiatric treatment for patients in the state mental hospitals it was realized that nursing personnel was very important.

> Milieu therapy-- the planned controlled use of the total hospital environment for the treatment of mental disorders-- has underscored the need for and importance of well-trained psychiatric nursing personnel. This treatment method received its greatest impetus in recent years from psychoanalysis. Such therapy is based upon an understanding of the genesis and dynamics of a particular patient's unique personality and unique illness. With this understanding the psychiatrist plans a hospital treatment program whereby specific activities and interpersonal relationships are prescribed to meet that patient's particular needs. The success of the program depends upon the skills of every member of the psychiatric treatment team. Milieu therapy is focused upon the importance of the relationships which the patient has with every person in the hospital environment. Since the patient's most frequent contacts are with nurses, we must recognize that these people play important and dynamic roles in the lives of the patients.[2]

In the mental hospital, as in all hospitals, the most direct

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link between the psychiatrist and the patient is the psychiatric nurse.

> Riding on a tide of enthusiasm to correct what Albert Deutsch has called appropriately the shame of the states heroic attempts have been made to improve the care of the mental patient by expedient measures to recruit and prepare nurses and attendants for mental hospital work.[1]

Upon the professional skills of the nurse rests the administration of the daily medical routine prescribed by the doctor, and the nurse's familiarity with the techniques of special therapies is an indispensable aid to the psychiatrist. She creates the atmosphere and determines the proper setting in which all therapy proceeds.

> In the nursing of mental patients, every bit of personality counts, every bit of intelligence counts, and every bit of insight as to what is going on in the patient's mind counts.[2]

In the following chapter the clinical team which was described in this chapter shall be seen in operation in a state mental hospital.

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[1] Ibid., p. 67.

[2] Harriet Bailey, In Nursing Mental Diseases (New York, 1920), p. 19.

CHAPTER IV

THE CLINICAL TEAM AT WORK IN THE INTENSIVE TREATMENT UNIT AT NORTHVILLE STATE HOSPITAL

Philosophy

Teamwork was something that was created and responsibility for its operation and outcome was shared by each participant.

> It is impossible to separate completely the medical from the ancillary therapies. The essence of a good program in a mental hospital is that every aspect of care or treatment, indeed everything that is done to, for, or with the patient is directed toward his immediate improvement and eventual recovery.[1]

> Treatment in the hospital is regarded as a total institutional process, rooted in medical responsibility, but with the psychiatrically oriented participation of every team member, each contributing to the total process on the basis of clearly established administrative allocations of responsibility and a well-grounded and disciplined attitude.[2]

The ultimate goal of treatment was seen as return of the patient to community living, with the fullest utilization of all medical resources for the personal, social, and vocational rehabilitation of the patient. Within the framework of a comprehensive service, the contributions of the various disciplines may have been pictured as a series of overlapping

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[1] Council of State Governments, Mental Health Programs of the Forty-Eight States (Chicago, 1950), p. 178.

[2] Group for the Advancement of Psychiatry, The Psychiatric Social Worker in the Psychiatric Hospital, No. 2 (Topeka, 1948), p. 2.

circles; each of the members, however, made a unique contribution to the treatment of the patient. In the Intensive Treatment Unit at Northville State Hospital, the psychiatrist, psychiatric social worker, psychologist, and the psychiatric nurse comprised the clinical team. What, then, was the unique contribution of each of these four disciplines in the treatment of patients in this Unit?

Role of the Psychiatrist

In the psychiatric hospital and clinic, the psychiatrist is the leader and the controlling member of the clinical team.[1]

> The concept that the psychiatrist always has the greater knowledge and experience is purely academic. Actually the extent of one's knowledge depends upon training and experience. It is no academic matter, however, that legally the psychiatrist must bear the final responsibility for the therapeutic task undertaken.[2]

The psychiatrist was the team leader in the Intensive Treatment Unit. He was responsible for the mental examination which was fundamentally a personality appraisal of the patient. In giving the mental examination, the psychiatrist should manifest respect for the patient and maintain the latter's self-esteem.[3] From this examination the psychiatrist was immensely helped

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[1]Editorial Committee, "Summary of Workshops on Current Trends in Psychiatric Settings and in Family and Children Agencies," Journal of Psychiatric Social Work, XXIV (April, 1955), 163.

[2]Adelaide Johnson, Psychoanalysis and Social Work (New York, 1953), p. 83.

[3]Arthur P. Noyes, op. cit., p. 139.

to diagnose the disorder in terms of classification, although not in terms of a genetic-dynamic formulation of the concrete life experiences of the patient.

After the mental examination was given, the psychiatrist was responsible for prescribing medication and somatic therapies for the patients. The medication was prescribed in accordance with the intensity of the mental disturbance. The somatic therapies prescribed were either electro-convulsive therapy, PM-10-90, or atropine; these therapies were given in accordance with the nature of the mental disturbance.

In the treatment of some patients in the unit the psychiatrists used individual psychotherapy. Psychotherapy was employed by many different psychological techniques, but the therapeutic factor common to all of them was the therapist-patient relationship with its interpersonal experiences. Group therapy was frequently utilized in the treatment of the patients in the unit.

> Group therapy recommends itself through the employment of the following factors: acceptance of the selected individuals, avoidance of unnecessary restrictions, permissiveness toward uninhibited verbal expression, and critical evaluation of reactions to group interaction as opposed to platitudinous judgment.[1]

Although each of the psychiatrists interviewed described the above role functions as their contributions to the treatment of patients in the unit, none of the ten cases read indicated that the patients had received individual or group

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[1] Ibid., p. 583.

psychotherapy.

Role of the Social Worker

The social worker's contribution to the treatment of the mental patients in the unit was based upon the generic training that every social worker has received. The generic training in social work is based upon the assumption that

> ...the individual and society are interdependent; social forces influence behavior and attitudes, affording opportunity for self-development and contribution to the world in which we live. Not only are all problems psychosocial-- inner and outer-- but most casework problems are interpersonal, that is, more than one person is likely to be involved in the treatment of the individual, and particularly in casework is the family unit involved; the client is a responsible participant at every step in the solution of his problems.[1]

The implications of the above statements by Gordon Hamilton were that the social worker was skilled in human relationships and in helping the individual move toward better social functioning through the use of his own strengths and society's resources. Because of the social worker's deep respect for the personality, worth and dignity, and right to self determination of the individual, he would attempt to see the client's problem as the client saw it, to allow him to move at his own pace, and to make his own decisions toward a goal that he was helped to set for himself. Therefore, the psychiatric social worker, in carrying out the full range of his functions, would share the common purposes, goals, and philosophy of all social

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[1]Gordon Hamilton, Theory and Practice of Social Case Work (New York, 1954), p. 22.

workers. There were, nevertheless, certain characteristics of a psychiatric social worker which need to be emphasized.

> Psychiatric social work is social case work, practiced in a psychiatric setting. Beyond the basic preparation which every social case worker has, the psychiatric social worker will have attained through clinical training a more comprehensive knowledge and a deeper understanding of the significant psychopathology, differential diagnosis, and treatment appropriately geared to this. The worker also has an integration of his skills in relation to that of others in the clinical team, hence a greater knowledge of the function and ways of working in related professional groups. The social worker's contribution to therapy will usually lie in his understanding of human interrelationships and the strengthening of the healthy aspects of the patient's personality by helping him to adjust to reality problems.[1]

In treating the patients it was essential to know their backgrounds and the sum of their life experiences as these things had shaped their personalities and were woven with mental processes. The psychiatric social worker's contribution of the social history was one of his major services to psychiatry. Although the social history had usually been obtained prior to a patient's transfer to the Intensive Treatment Unit, frequently the history was not completed until after the transfer. It, therefore, seemed necessary to point out the obtaining of the social history as a function of the social worker in the Intensive Treatment Unit. The social history was compiled from information revealed as an outgrowth of a purposeful relationship of the social worker with the patient, members

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[1]Group for the Advancement of Psychiatry, The Psychiatric Social Worker in the Psychiatric Hospital, p. 2.

of his family, physicians, and agencies acquainted with the patient and other community resources with which the patient might have had experience. The history was viewed as a dynamic service which increased the total understanding of the patient's difficulty, and facilitated the development of changing plans in both hospital and after-care treatment programs. At the time that the history was obtained the social worker helped the patient's family to understand the patient's illness and pointed out what could be done both by the hospital and by the relatives to improve the patient's mental condition.

Upon referral from the psychiatrist the social worker gave continued case work treatment to the patients and their families. Casework treatment of the patients was a supportive type in which the worker attempted to strengthen the healthy aspects of the patients' personalities by helping them to adjust to reality problems with increasing emotional satisfaction. In commenting on continued case work treatment with the patients and their families, the Committee on Psychiatric Social Work of the Group for the Advancement of Psychiatry stated

> ...the social worker is recognized as the most effective person for maintaining a continuous contact between the patient and his family. In this relationship, an effective liaison could be maintained, and adequate consideration could be given to emotional problems arising, either in the family or with the patient himself. This would insure a continued dynamic relationship with the community, and in this manner, it would be possible to evaluate the home situation with regard to prescribed or contemplated visits or preparing the family for the re-acceptance of the patient. It was seen that the relationship of the social worker with the family during continuous treatment made him a strategic person to the

> patient and the psychiatrist as well as other hospital personnel. The social worker's awareness of the patient's program and progress will be reflected in the pace of the preparation of the family for the patient's discharge. The degree of readiness of the home to receive the patient will be invaluable to the psychiatrist in the planning and treatment.[1]

Referrals from the psychiatrist to the social worker often included requests for the rendering of tangible or material services to patients in the unit. Such services included verifying financial status, assisting in settling of transactions concerning a patient's property or insurance, and requesting of funds from family members for clothing, glasses, dentures, etcetera.

The social worker was responsible for making pre-convalescent evaluations on the patients in the unit. These evaluations were referred to as Ten Day Leaves and Thirty Day Leaves. Many times the social worker had had no contact with the patient or the family prior to the request for an evaluation.

> A hasty evaluation based upon an interview with a relative and with the patient may enable the worker to make a superficial judgment as to whether the home situation will help or hinder the patient's regained power to function again within it, but it can scarcely result in the understanding of underlying factors, or bring about the joint working together of family and worker. Such outcomes are of longer contact existing from the day of commitment to the time of discharge. Of course, the nature of the contact of the worker with the patient and family during hospitalization will be dependent upon the circumstances of the case.[2]

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[1] Ibid., p. 9.

[2] Lois Meredith French, op. cit., p. 129.

When a patient had received maximum benefit from hospitalization but was not ready to return to his home, family-care was often utilized. Under the family-care program, foster homes had been located and studied to insure meeting the patient's needs for care. The social worker, after consultation with the psychiatrist, was responsible for arranging the placement of the patient. This process involved working with the patient in his preparation for the placement, as well as with the foster family, and with members of the patient's own family. The social worker had continuous contact with the patient and the foster home. This was important to assist the foster family with the problems they encountered in living with the patient.

During the period of convalescence, the social worker exercised continued supervision of the patient. He assisted with readjustment problems as they arose within the patient's family or in solving the patient's difficulties in his efforts to resume his place in the life of the community.

In the interviews with the social workers assigned to the unit the above role functions were described as being unique contributions of the social worker to the treatment of patients in the unit. When the ten cases were read it was found that social histories had been obtained on all of the cases. Only one patient had received tangible services from a social worker, and two patients had received continuous casework services from a social worker. The remaining seven patients had had contact with a social worker for pre-convalescent evaluations

and convalescent follow-ups only.

Role of the Psychologist

The contributions of the psychologist to the treatment of mental patients was indispensable. The use of the special testing techniques and interpretative skills for the measurement of human behavior constituted the major contribution of the psychologist to diagnosis.

> Psychological examinining is not a matter of machine tending; it is a complex human relationship calling for all the skills and sensitivities demanded by any situation requiring the establishment of rapport. Besides having an insightful knowledge of the diagnostic and prognostic aspects of the test findings, the examiner must be sensitive to their therapeutic implications. The psychologist must have enough security, on one hand, not to escape into exactness about the insignificant and, on the other hand, not to escape into meaningless profundities because he is overcome by the complexity and difficulty of the significant. He must have a sense of responsibility about his test findings-- an appreciation of the fact that they make a real difference to a particular individual and to those involved with him.[1]

At Northville, the psychologist, upon referral from the psychiatrist, was responsible for administering psychological tests to patients. The projective tests took a very prominent place in the batteries of tests used in the clinical setting. The major instruments in this area were the Rorschach and Thematic Apperception Tests. The Rorschach Test consisted of a set of ink blots to which the patient was requested to give associations. This test revealed formal characteristics of

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[1]Franz Alexander, M.D., and Helen Ross, op. cit., p. 463.

personality such as intellectual creativity, autism, richness or poverty of association, capacity for outwardly directed affectivity, egocentricity, capacity for social rapport, degree of control over intellectual processes, adaptability, introversion, self-appraisal, orderliness, aggressiveness, and conformity. The Thematic Apperception Test consisted of a series of pictures arranged in separate groups for male and female subjects and for adults and children. The patient was instructed to regard each picture as an illustration and was then requested to tell a story to go with it, identifying the characters, explaining their relationship to one another, and giving the background for the situation and its outcome. One obtained from the analysis of this data considerable information about the patient's background, preoccupations, and latent trends, including his attitudes, ideals, and needs, and his relationships to important persons in his environment. These two tests were complementary and were used together as a particularly desirable clinical practice.

The psychologist's second contribution was in the realm of research. With the pressing and limitless range of research needs in the field of personality, the psychologist is becoming more and more concerned with research.[1] The psychology department at Northville State Hospital was responsible for the Research Co-ordination Program, and at the time of this study

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[1] Ibid., p. 478.

they were making objective studies in the evaluation of the effects of somatic therapies on the patients' behavior.

Interviews with the psychologists revealed the above role functions as being the contributions of the psychologist to the treatment of the patients. From reading the ten case records, it was ascertained that nine of these patients had been given psychological examinations while in the unit.

Role of the Nurse

In general, psychiatric nursing is a part of all nursing. It is defined as the art of observing and favorably influencing the patient toward mental health and away from mental disorder.[1]

> A statement of this kind carries with it implications which concern the acceptance of the concept that whenever a nurse can favorably influence a patient toward health and away from illness, then she is truly performing her nursing function.[2]

Psychiatric nurses in the Intensive Treatment Unit served as supervisors of attendants who took care of most of the physical requirements of the patient. The nurses were very concerned with more than the physical care of the patient; their responsibility included an intimate knowledge of the patient's needs and the nature of his mental disturbances. The patients were informed about nursing measures to minimize fear

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[1] Alfred Stanton, M.D., and Morris Schwarz, Ph.D., The Mental Hospital (New York, 1954), p. 154.

[2] Ibid.

aspects and to help to reduce anxiety.

The nurses in the unit assisted the psychiatrists with the administering of somatic therapies. Their understanding of the techniques of these therapies was an indispensable value to the psychiatrists who applied them.

The psychiatric nurses, through patience, perseverance, and constant vigilance, attempted to train the patients in good personal habits and to guide them into normal channels of living. They charted or supervised the attendants in charting the patients' changes of mood, attitudes, appearance, and various reactions to the day's activities. Revealing conversations, any slight defects of memory, mistaken ideas, gross errors of judgment, fears, and unusual or bizarre behavior were also charted.

In interviews with the psychiatric nurses the above role functions were described as being the nurse's contributions to the treatment of the mentally ill patient. In all of the ten cases read, nursing observations were recorded.

Relationship in the Clinical Team

To treat the patients with maximum efficiency the relationship of the team was of ultimate importance. Effective teamwork was dependent largely upon the members' attitudes and feelings toward each other. The members of the team should understand clearly and objectively the function of each discipline in order to collaborate skillfully. In commenting on

effective teamwork Maurice Connery stated

> ...teamwork is an interpersonal process. To function effectively within the structure of the team, individual members must recognize this fact and strive to understand its implications to their roles and responsibilities in the process. Teamwork develops from a discovery of self and of others and from a conscious effort to implement this insight in the joint activity.[1]

The development of a team member's positive attitude toward the other team members seemed to depend upon his knowledge of the content of professional training that each discipline had received. The positive attitude would also be dependent upon the team member's previous experiences in professional interrelationships with other disciplines. All members of the four disciplines interviewed were very familiar with their role functioning in the treatment of the patient but had a limited awareness of the role functioning of other disciplines in the treatment of the mental patient. In discussing the interviewees' previous experiences in psychiatric settings it was found that none of the psychiatrists had had previous experiences in a setting wherein the multi-disciplinary approach was utilized for the treatment of illness. Two of the social workers had had previous experiences in psychiatric settings which used the team approach to treatment. Three of the psychologists had had previous experiences in psychiatric settings which utilized the team approach to the treatment of

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[1]Maurice Connery, "The Climate of Effective Teamwork," Journal of Psychiatric Social Work, XXII (January, 1953), 60.

mental illness. None of the four nurses had had previous experiences in a psychiatric setting wherein the multi-disciplinary approach to treatment was used.

Walter Lesser stated that consultation was the thread that ran through the entire process of treatment, and in commenting further on consultation he said

> Consultation is the co-ordinating and integrating force that runs through a successful team operation, which in turn leads to a meaningful treatment experience for the patient. The mastery and use of this communication device by each team member influences most aspects of team functioning, including diagnosis and team, supervisory, and medical conferences.[1]

Adelaide Johnson made other comments about effective team operation which should be mentioned at this time.

> It is impossible to achieve much for the patient if, within the team, respect and mutual friendliness are lacking. The patients soon sense competitiveness, narcissism, defensiveness, and overprotectiveness in the team members, and the treatment progress is prevented. The benefit achieved, therefore, from frequent discussion of cases is, in addition to research, the assistance one gives another to see what he might not see because of countertransference difficulties. In the course of discussion, resistance frequently springs from over-identification with one's patient. Therefore, collaborative conferences, to be of clinical value, must transpire, as has been said, in an atmosphere of friendliness and respect.[2]

From interviews with the members of the four disciplines who comprised the clinical teams in the Intensive Treatment Unit

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[1]Walter Lesser, "The Team Concept-- A Dynamic Factor in Treatment," Journal of Psychiatric Social Work, XXIV (January, 1955), 126.

[2]Adelaide Johnson, op. cit., p. 84.

at Northville State Hospital, it was ascertained that routine consultation periods were held by only two wards in the unit; these consultations rarely included the psychologists. Administratively, weekly consultations between the psychiatrists and the social workers were to be held; this procedure was adhered to. Communication and exchange of information between the psychiatrists and the nurses were conducted on the day-to-day ward rounds and by the use of medical charts. The psychiatric social workers made daily ward rounds and also had consultations with the nurses during these rounds. There was no organized exchange of information between the psychologists and other members of the team until a patient was to be presented to therapeutic staff, at which time some of the psychiatrists consulted the psychologists about the psychological findings in the particular case before the patient was seen in therapeutic staff conference.

When asked for suggestions for the instigation of an effective team relationship, all interviewees stated that meetings of ward teams at scheduled times would be quite effective. These team conferences would adher to the basic philosophy underlying the teamwork concept as given by Florence Stein:

> ...Here we take into consideration the fact that each member's contribution is focused toward the primary purpose which is better service to the patient and the patient group. Personal prominence is subordinated to the efficiency of the whole in effective teamwork. In subordinating personal prominence, each member of the group thinks in terms of how his individual contribution may be related to the function of the other individual members of the team. Each member also considers what he can learn from the other members of the team to improve

> and supplement his own particular service to the patient. We, thus, find the group working together with the goal of seeing that the patient gets the best service available to evaluate his problem.[1]

Another suggestion given by all interviewees was that the various role functions of the disciplines comprising the clinical teams be given administrative clarification. The implication of this suggestion was that because of inadequate administrative clarification of role functions of team members, the utilization of the services of the disciplines are often ineffective, inappropriate, and economically wasteful. If there were clarification, professional manpower would not be wasted, and the teams would work together more effectively.

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[1]Florence Taub Stein, "Teamwork in a Medical Setting: A Skilled Process," Readings in the Theory and Practice of Medical Social Work, ed. Dora Goldstine (Chicago, 1954), p. 287.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study, a descriptive presentation of the operation of the clinical team in the Intensive Treatment Unit at Northville State Hospital, located in Northville, Michigan, was begun with a recapitulation of the changing methods of treating the mentally ill in state mental hospitals in America. The treatment of the mentally ill went through numerous stages. Prior to the termination of the nineteenth century, the methods of treatment for the mentally ill were repressive, isolatory, and purely custodial. With the advent of dynamic approaches to psychiatric theory and practice, significant insight into the methods of more effective treatment of mental illness was achieved, and the concept of the use of the clinical team in the state mental hospitals was initiated. The use of the clinical team was a multi-disciplinary approach to treatment, wherein the skills of four disciplines were pooled and shared in an effort to provide a scientific understanding of the patient's emotional disorder. World Wars I and II, and the passage of the National Mental Health Act in June, 1946, strengthened the structure and objective of the clinical team.

In describing the operation of the clinical team in the Intensive Treatment Unit at Northville State Hospital, an effort was made to show how the services of the psychiatrists, social workers, psychologists, and psychiatric nurses were

utilized with the ultimate goal of helping the mentally ill patient return to community living. Each of these members of the clinical team rendered specific services in the treatment of the patients.

The psychiatrists in the unit were the team leaders. They were responsible for giving the patients' mental examinations, prescribing medication and somatic therapies. They also gave individual and group psychotherapy if the patients could benefit from them.

In the performance of their roles as psychiatric social workers, the social workers employed the basic skills and techniques characteristic of their profession. They took social histories, gave continuous supportive casework treatment to the patients in the unit when referred by the psychiatrists, made pre-convalescent evaluations on the patients, rendered tangible services to the patients, supervised patients in family-care homes, and made convalescent follow-ups.

As members of the team, the psychologists were responsible for administering objective and projective tests to the patients. They were responsible also for the research projects in regard to the effects of the somatic therapies on certain patients' behavior.

The psychiatric nurses supervised the attendants in their performance of physical care of the patients. They assisted the psychiatrists in the administering of somatic therapies, and gave medications. They charted, or supervised the charting of the patients' changes in mood, attitudes, appearances,

revealing conversations, and various reactions to the ward activities. The psychiatric nurses were both observers and listeners in their contacts with the patients in the unit.

The conclusions of the study were as follows: (1) administratively, the clinical teams in the Intensive Treatment Unit were composed of psychiatrists, social workers, psychologists, and psychiatric nurses; (2) these teams were teams in name only as there were very limited consultations between the members of the teams; (3) those team members who had had previous experiences in professional relationships with other disciplines collaborated more effectively within the team than those who had had no previous experiences in such settings; (4) team members who had a knowledge of the content of professional training that each discipline had received had positive relationships with other team members; (5) the consensus of the team members in the Intensive Treatment Unit was that scheduled group meetings of the ward teams would lend an opportunity for the four disciplines to exchange information in regard to treatment planning for the patients in the unit; and (6) there should be an administrative clarification of the functions of the various disciplines in the treatment of the patients in the hospital.

The writer would reiterate that comprehensive treatment of mental illness requires an interdisciplinary approach. The suggestions given by the team members in the Intensive Treatment Unit for the instigation of a more effective team relationship

might lend a decided impetus to the goal of comprehensive treatment for the mentally ill patient.

APPENDIXES

A. INTERVIEW SCHEDULE

B. SCHEDULE FOR CASE RECORDS

APPENDIX A

INTERVIEW SCHEDULE

1. Identifying Data
   a. Code number_____
   b. Job classification_____
   c. Have you worked in a psychiatric setting previously?
   d. How long have you worked at Northville State Hospital?
2. Services Rendered by the Members of the Clinical Team
   a. Psychiatrist
      (1) Mental examination_____
      (2) Prescribing medication & somatic therapy_____
      (3) Psychotherapy_____
      (4) Group therapy_____
   b. Psychiatric Social Worker
      (1) Social history_____
      (2) Casework with patient_____
      (3) Casework with relatives_____
      (4) Tangible services_____
      (5) Family-care supervision_____
      (6) Pre-convalescent evaluations_____
      (7) Convalescent follow-ups_____
   c. Psychologist
      (1) Administering of objective & projective tests____
      (2) Research_____
      (3) Psychotherapy in collaboration with the psychiatrist_____

d. Nurse

(1) Supervision of ward personnel_____

(2) Physical care_____

(3) Giving medication_____

(4) Charting of observations on patient's behavior on the ward_____

3. Do you have consultations with other team members regarding patients with whom you are working? Yes_____ No_____

4. Do the case records indicate that you have conferred with other members of the team in regard to patients with whom you are working? Yes_____ No_____

5. How do you feel that the clinical team could operate more effectively?

APPENDIX B

SCHEDULE FOR CASE RECORDS

1. Identifying Data
   a. Code number_____
   b. Date of admission to the unit_____
   c. Date of placement on convalescent status_____
2. Check If Services Were Received from the Following Persons:
   a. Psychiatrist only_____
   b. Psychiatrist & Nurse_____
   c. Psychiatrist, Nurse & Social Worker_____
   d. Psychiatrist, Nurse, Social Worker, & Psychologist _____
3. Check Types of Services Rendered by Each Team Member:
   a. Psychiatrist
      (1) Mental examination_____
      (2) Prescription for medication & somatic therapy _____
      (3). Psychotherapy_____
      (4) Group therapy_____
   b. Psychiatric Social Worker
      (1) Social history_____
      (2) Casework with patient_____
      (3) Casework with relatives_____
      (4) Tangible services_____
      (5) Family-care supervision_____
      (6) Pre-convalescent evaluation_____
      (7) Convalescent follow-ups_____

c. Psychologist

(1) Administering objective & projective tests_____

(2) Research_____

(3) Psychotherapy in collaboration with the psychiatrist_____

d. Nurse

(1) Giving medication_____

(2) Charting of observations on patient's behavior on the ward_____

4. Is there evidence of consultation between team members in regard to the treatment planning for the patient?

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